

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXXX

Petitioner

v

File No. 121567-001

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this 17th day of October 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On May 24, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on June 1, 2011.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on June 9, 2011.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM *Community Blue Group Benefits Certificate* (the certificate), as amended by three riders: *CBD \$250-P (Community Blue Deductible Requirement for Panel Services)*, *CBC 20%-P (Community Blue Copayment Requirement for Panel Services)*, and *CB-CM-P \$1,000 (Community Blue Copayment Maximum for Panel Services)*.

The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On January 11, 2011, the Petitioner had eyelid surgery performed by a participating physician. The total charge was \$5,600.00. BCBSM approved \$3,475.37 for this care. Because the Petitioner's deductible had not been met, \$250.00 was applied to her deductible. Petitioner was also charged a copayment of \$645.05 (20% of the approved amount less the deductible).

The Petitioner believes that she should not be assessed a copayment because a BCBSM representative told her that the surgery would be fully covered. Petitioner appealed BCBSM's decision. After a managerial-level conference on April 13, 2011, BCBSM affirmed its claim processing and issued a final adverse determination dated April 25, 2011.

III. ISSUE

Did BCBSM correctly apply a copayment to the Petitioner's surgical services?

IV. ANALYSIS

Petitioner's Argument

In October 2010, the Petitioner was having problems with her peripheral vision due to her sagging eyelids. After testing, it was determined that she needed surgery.

The Petitioner states she contacted BCBSM and was told that her surgery would be covered. When she asked if there would be a copayment, she states that she was told it would be fully covered. Based on this information, she went forward with the surgery.

Later, the Petitioner received a bill from her doctor for \$521.00. She also received an explanation of benefits from BCBSM that indicated she had a 20% copayment. When she called BCBSM she was told if the surgery was performed in the physician's office there would be no copayment, but that a 20% copayment applies if performed in a clinic or surgical center.

The Petitioner argues that if the copayment provision had been fully explained to her it would have made a difference in the way she handled the surgery. She had been given the names of three doctors who perform this surgery and she could have found out if any perform it in an office setting. If none of them did, she could have opted to not have the surgery or to have a deduction from her paycheck increased to cover the cost of surgery.

BCBSM's Argument

Rider *CBC 20%-P* requires a 20% copayment for services by a provider who is part of the BCBSM panel of providers. The rider includes the following provision in the section *Limitations and Exclusions*:

This copayment does not apply to:

- Covered services performed in a panel physician's office

Rider *CBD \$250-P* requires a \$250 deductible for most covered services.

Under her certificate, the Petitioner is not required to pay a deductible or copayment for "... covered services performed in a panel physician's office, including presurgical consultations." However, her services were not performed in a physician's office; they were performed in an ambulatory surgical center.

According to BCBSM, in the Petitioner's October 4, 2010, inquiry to BCBSM she questioned the out-of-pocket costs of surgery and an office visit to her doctor. There is no record that she inquired about service performed in a location other than her doctor's office. Therefore, BCBSM argues that the Petitioner was provided with the correct information in response to the question the Petitioner asked.

Commissioner's Review

Rider *CBC 20%-P* provides that a 20% deductible applies to panel services. The copayment does not apply when services are provided in a panel physician's office. However, the Petitioner's January 11, 2011, surgery was provided in an ambulatory surgical center and not in a physician's office. Therefore, the copayment applies to the surgery.

Petitioner believes that her surgery should not be subject to any copayment because she was misinformed by BCBSM and relied on the information given by the BCBSM representative. BCBSM contends the information given the Petitioner was accurate and not misleading.

The Commissioner cannot resolve this factual dispute about whether or not BCBSM misinformed the Petitioner. Under the Patient's Right to Independent Review Act (PRIRA), the Commissioner's role is limited to determining whether BCBSM properly administered health care benefits under the terms and conditions of the applicable insurance certificate and riders. Resolution of factual disputes such as the one described by the Petitioner cannot be part of the PRIRA review because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds that BCBSM's application of a 20% copayment was consistent with the terms of the Petitioner's benefit plan.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of April 25, 2011, is upheld. BCBSM is not required to waive the copayment charge for petitioner's surgery.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.